

Revised 12/95

HEALTH CARE FINANCE AND SERVICE DELIVERY REFORM PROGRAM

COUNTRY ACTION PLAN

KAZAKHSTAN

Submitted to the  
United States Agency for International Development  
Regional Mission for Central Asia, Almaty, Kazakhstan  
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## EXECUTIVE SUMMARY

The Health Care Finance and Service Delivery Reform Program (HCFSDR) is a three year NIS wide program, with an option of an additional two years. Approximately 32 percent (or \$13.0 million) of the total three year program budget is allocated to the Central Asia Region countries of Kazakhstan and Kyrgyzstan. This Country Action Plan provides the program strategy for Kazakhstan.

Assessments carried out by the HCFSDR, other USAID-funded programs, and other donors, as well as the predecessor Health Finance Sustainability Project, have revealed a number of constraints that must be addressed in order to achieve substantive reform of the Kazakhstani health financing and service delivery systems. The major areas of constraint include decreased level of funding to the health care sector and inefficient use of available resources and lack of incentives to improve productivity.

The goal of the HCFSDR program in Kazakhstan is to strengthen the capacity to manage the human dimension of the transition to democracy and a market economy by improving the sustainability of social benefits and services.

The general program strategy is to parallel current economic reforms by creating competition among health care providers and increasing efficiency. The aim of the strategy is to improve the financial sustainability of the health care sector by increasing the efficiency and productivity of the health care sector.

To achieve improvements in efficiency, quality and access to health care services in Kazakhstan, the program will focus its resources on achieving the following programmatic outputs:

1. Privatization/restructuring of the Farmatsiya state holding company.
2. Rational drug management and information system developed and tested in pilot facilities.
3. New provider payment methods developed for national Basic Health Insurance (BHI) Fund and tested in pilot facilities with BHI services.
4. Improved quality assurance, financial and clinical information systems designed and tested in pilot facilities with new provider payment methods.

The total cost of the HCFSDR program in Kazakhstan, for the period 1/1/96 through 12/31/96, will be \$2,754,536.

# KAZAKHSTAN COUNTY ACTION PLAN

## GENERAL PROGRAM STRATEGY

Kazakhstan is a developed country experiencing a transition from a command to a market economy. The goal of the Health Care Finance and Service Delivery Program in Kazakhstan is to strengthen the capacity to manage the human dimension of the transition to democracy and a market economy by improving the sustainability of social benefits and services (Strategic Assistance Area 3 and Program Objective 3.2).<sup>1</sup>

The program strategy is to parallel current economic reforms by creating competition among health care providers and increasing efficiency. To do so, incentives and relationships must be changed between the government, facilities, physicians, and consumers.

The constraints to achieving the program goal are the following: 1) reduced availability and high cost of pharmaceutical products, 2) decreased level of funding to the health care sector and, 3) inefficient use of available resources and lack of incentives to improve productivity. Two development strategies will be followed to address the constraints: 1) improving the availability of pharmaceuticals and utilization of drug resources (Section I), and 2) improving the financial sustainability of the health care sector by increasing the efficiency and productivity of the health care sector (Section II).

The program will focus its limited resources and time on achieving the following outputs with the anticipated impact of improved efficiency, quality, and access to health care services:

1. Privatization/restructuring of the Farmatsiya state holding company.
2. Rational drug management and information system developed and tested in pilot facilities.
3. New provider payment methods developed for national Basic Health Insurance Fund and tested in pilot facilities with BHI services.
4. Improved quality assurance, financial and clinical information systems designed and tested in pilot facilities with new provider payment methods.

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<sup>1</sup> Except for the drug information system under Program Objective 3.4, the entire project addresses Program Objective 3.2 and the impact indicator "improved efficiency, quality and access to health care". For simplicity of presentation, the plan document does not repeat the Program Objective and impact indicator for each output.

## **I. PHARMACEUTICAL SECTOR**

**Constraint:**                    **Reduced availability and high cost of pharmaceutical products**

**Output 1.**                    **Privatization/Restructuring of Farmatsiya State Holding Company**

This output meets the Strategic and Program objectives by establishing a competitive market to improve efficiency and allocation of resources in the pharmaceutical sector.

Kazakstan has been experiencing a significantly reduced availability and range of drugs, and spiralling prices which make many drugs, even if available, unaffordable for large segments of the population. The quasi-monopoly power of the Farmatsiya state holding company has been a major contributing factor to this crisis, and the breakup and privatization of most or all of the components of this holding company is an essential condition for improving drug availability and reducing consumer prices for pharmaceuticals (complete plan for Farmatsiya restructuring and privatization contained in Appendix A). ZdravReform has already succeeded in dismantling the state holding company, and has made significant progress towards privatization of a majority of retail pharmacies and the sale of shares in the state companies controlling the wholesale distribution of drugs. In addition, ZdravReform continues to develop and redefine a system of regulation and control of the pharmaceutical industry that will allow private pharmacies to compete on an equal footing with state-owned structures.

A further element of the program consists of efforts aimed at improving the ability of private pharmaceutical wholesalers, distributors and retailers to compete and to achieve efficiencies that will increase the availability and lower the retail prices of drugs. ZdravReform is developing and carrying out a program of targeted technical assistance and training to transfer essential business management skills to private sector pharmacy managers and owners.

Starting in January, 1995, ZdravReform, in collaboration with other AID contractors, has made significant progress towards achieving all of these objectives. ZdravReform staff assisted the Ministry of Health and the State Property Management Committee (GKI) in drafting and obtaining approval for two critical pieces of legislation. The first, a Cabinet of Ministers Decree approved in April 1995, mandated the dissolution of the Farmatsiya State Holding Company, an essential precondition for privatization. The second, a GKI decree, instructed the territorial committees responsible for privatization in each oblast to prepare plans for the restructuring and privatization of the Farmatsiya joint stock companies in each oblast and providing guidelines for the preparation of such plans. A third GKI decree, also drafted by ZdravReform staff and specifying exactly which retail pharmacies are to be privatized, is still under review.

As a result of this legislation and also of ZdravReform assistance to oblast authorities in drafting their restructuring plans, more than 250 retail pharmacies had been auctioned by the end of November 1995, and more than 120 sold. Approximately 100 additional pharmacies had been given or leased to their employees, and another 600 were being prepared for auction by the oblast committees. Completion of this process would result in more than 70% of the retail pharmacies in Kazakhstan being privately owned and managed.

In early December, the first auctions of the state share package in eight oblast joint-stock Farmatsiya companies were announced, to take place at the end of December. Although the legal and managerial issues requiring resolution may prevent these auctions from taking place as scheduled, it is nonetheless a clear sign of progress towards privatization of wholesale pharmacies, a process that should be completed by mid-1996.

ZdravReform staff, collaborating with other AID contractors, has developed plans for a modular system of business management, marketing, procurement, and financial management assistance to private pharmacies, to be carried out during 1996.

The targets to be used to measure progress toward achievement of Output 1 are:

- 1. Pharmaceutical distribution and retail pharmacies moved from public sector to private sector by 6/96.**
- 2. Fair and neutral pharmacy regulations that treat state and private pharmacies equally developed and adopted by 3/96.**

**Specific Activities and Completion Date:**

1. Wholesale Farmatsiya operations prepared for privatization. (March 1996)
2. Wholesale Farmatsiya operations sold. (Jun. 1996)
3. Regulations for licensing of drug distribution, pharmacies, and pharmacists established by MOH. (March 1996)
4. Information/Education campaign to create public awareness of privatization benefits conducted. (Oct. 1996)
5. Retail pharmacies sold through small-scale auction process. (May 1996)
6. In-country training program in business and management for key pharmaceutical owners/managers conducted. (Oct. 1996)

**Output 2. Rational drug management and information system established and functioning in pilot areas.**

This output meets the Strategic and Program objectives by rationalizing drug procurement through introduction of a national essential drug list and oblast and health care facility formularies to increase access, quality and efficiency in the provision of pharmaceutical products to the population.

The restructuring of Farmatsiya is only part of the solution to the problem of delivering essential drugs to the population. Another equally important part is the introduction of drug procurement policies consistent with the financial means available, which in turn will effect prescribing practices of physicians. Currently, many of the commonly-used drugs in Kazakhstan have either limited clinical effectiveness or are recently-introduced more expensive brand names. Cheaper, more

effective drugs are available on the international market but are not utilized because of inadequate planning and procurement systems, which in turn are hampered by the lack of information of the range of drugs available. Examination and modification of the current system is required to restrict the range of drugs commonly prescribed and purchased so as to achieve the maximum therapeutic benefit for the resources used. In addition, as a result of pharmacy privatization, the procurement and distribution of drugs will increasingly depend on the private sector.

A formulary system will also impact purchasing of pharmaceuticals in the private market. Instead of stocking all drugs, formularies will encourage pharmacies to stock essential drugs, because formulary drugs will be ordered by hospitals and prescribed by physicians. Restricting the number of pharmaceuticals will increase competition, which will decrease price and improve availability. The creation of a functioning formulary system will aid Kazakhstan in using its limited resources available for the health sector in the most cost-effective manner. Formularies can also provide the basis for creation of a drug benefits program which can be used by the basic health insurance Fund.

To support the formulary system, a drug information system is needed, as many of the drugs on the new formularies will be unfamiliar to physicians. The drug information system will contain new and regularly updated information on the pharmacological properties of drugs on the formularies and national essential drug list and appropriate use. Improved drug information can itself accelerate the move to more rational procurement and prescribing practices.

ZdravReform has completed the first draft of a national essential drug list, based upon the WHO essential drug list, containing a limited selection of therapeutically effective, cost-efficient pharmaceuticals. The final version of the national list is expected to be approved by the Ministry of Health by January, 1996. The list will be used by oblasts and health care facilities to develop individual drug formularies. These formularies, developed with active involvement of local medical staff, will meet the needs of their communities. Development work on hospital and polyclinic formularies has been initiated in three pilot sites: Shymkent, Almaty and Atyrau, and an oblast formulary developed and under review in Dzhezkasgan oblast.

The targets to be used to measure progress toward achievement of Output 2 are:

- 3. National essential drug list developed and adopted by 2/96.**
- 4. Improved drug formularies developed and adopted in one pilot oblast and in pilot facilities in another three oblasts by 6/96.**

#### **Specific Activities and Time Schedule:**

- 1 Oblast formulary developed and adopted in Dzhezkasgan (Jan. 1996).
2. Formularies developed for pilot facilities in Almaty, Shymkent, Dzhezkasgan, and Atyrau (Mar. 1996).
3. Monitoring system implemented to track availability and prices of formulary drugs (Mar. 1996).
4. Drug information system created to support the formulary system (June 1996)

5. Educational programs developed and implemented for physicians from pilot oblast and pilot facilities with formularies on the use of new formulary and selected medications (June 1996).
6. Model procurement systems developed for implementation of oblast and facility formulary systems (June 1996).

## **II. HEALTH SECTOR FINANCING AND EFFICIENCY**

**Constraint:**                    **Inefficient use of available health sector resources and lack of incentives to improve productivity.**

**Output 3:**                    **New provider payment methods developed for national Basic Health Insurance Fund and tested in pilot facilities with BHI services.**

This output meets the strategic and program objectives by changing the economic incentives of the health sector, resulting in more efficient provision of quality health services.

Kazakhstan is currently experiencing a crisis in funding the health sector. Even before the break-up of the Soviet Union, the percentage of the GNP devoted to health was significantly less than other industrialized countries. The situation has significantly deteriorated since independence. The percentage of the GNP devoted to health, which had been 6% in the 1980s, declined to approximately 3.3% in 1990, to 1.6% in 1992, and rose to 2.8% by 1994.

One of the principal concerns of the health sector is how to generate additional resources for health care that are independent of the state budget. National authorities have chosen to accomplish this by establishing oblast health insurance funds to pool premiums from employers and national budget monies. The basic health insurance (BHI) funds will reimburse providers for services included in a minimum benefits package. The BHI fund would potentially decrease the scope of government support and facilitate the development of private insurance and user fees for supplemental benefits not contained in the minimum benefits package.

In June 1995, legislation was passed mandating the establishment of a basic health insurance (BHI) fund in each oblast by January 1, 1996. Progress in fulfilling this mandate has so far been slow due to lack of knowledge and experience with health insurance systems, political infighting, and conflicting or ambiguous laws and decrees which have curtailed the implementation of some activities. The recently-created federal level BHI Fund has authority from the Cabinet of Ministers to regulate implementation of the oblast funds. The federal Fund has requested ZdravReform to provide policy guidance on instituting new, incentive-based payment methods for hospitals and outpatient facilities.

Establishing new payment methods is key to increasing the efficiency of the health sector, leading the way to a sustainable future health budget. The health sector will be able to provide more health services with current funding levels due to more efficient allocation of existing resources. The BHI Fund provides the structural mechanism to introduce payment reforms.

Hospitals currently have little incentive to increase their efficiency. Resources are centrally allocated based on input measures like number of beds, rather than quality and complexity of services. The result is strong incentives to maintain excess bed capacity and keep patients in the hospital longer than necessary. The excess bed capacity leads to high fixed costs in the health sector.

The provider payment system basis should be changed from planning norms to a system that rewards efficiency, such as a case-based method of payment (hospitals are reimbursed a set amount adjusted for complexity for each patient discharged). Efficiency will improve as hospitals respond to incentives to keep patients in the hospital for less time and shift non-acute patients into primary care and sub-acute facilities.

A portion of the excess bed capacity may be converted into skilled nursing facilities providing less expensive services to sub-acute patients, although some facilities should be closed. A rationalization plan for health facilities, together with the impetus of payment system incentives, should reduce the overcapacity and fixed costs in the health sector.

The problems in the primary care sector are reinforced by the polyclinic financing method. Polyclinic budgets are based on staff and capacity, like hospitals the incentive is to increase capacity, not provide quality services. In addition, physicians are salaried and underpaid. Lacking incentives to increase income, they act as indifferent dispatchers referring patients to hospitals, further increasing hospital costs.

As with hospitals, physician payment methods need to be refined to create different incentives. One alternative is a capitation method: a fixed payment per person adjusted for health characteristics such as age and sex. The use of capitated payment means that primary care physician income is based on the number of patients who enroll in their group and effective treatment of those patients. Incentives under capitated payment are to increase productivity and decrease referral rates.

Technical assistance and training for the design and implementation of new payment methods will be targeted at the federal level, through the federal BHI fund, and the oblast level in selected pilot sites. Assistance at the federal level will be in policy advice and design of payment methods to be implemented through the Fund. Some assistance may also be provided on rationalization planning and information and quality assurance systems to support payment methods. At the oblast level, Project inputs will be focused on operationalizing new payment methods in pilot areas which will serve as demonstration models for future replication in other facilities/oblasts. Specifically, continued assistance will be provided to: (1) South Kazakstan to establish a health maintenance organization (HMO) and primary care fundholding in selected family practices, (2) Dzhezkasgan to refine payment methods for hospitals and private practices<sup>2</sup>, and (3) Almaty oblast to implement primary care fundholding systems in two pilot polyclinic facilities.<sup>3</sup>

The target to be used to measure progress towards achievement of Output 3 is:

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<sup>2</sup> Mercy Corps International awarded a grant of \$25,000 to the Dzhezkasgan BHI Fund to purchase a computer network for their management information system.

<sup>3</sup>This activity will be carried out in collaboration with the Know How Fund who will be providing clinical training for primary care physicians and assistance in rationalizing/modernizing clinical protocols.

**5. New payment methods developed for National BHI Fund and tested in pilot facilities in three oblasts by 8/96**

**Specific Activities and Completion Date:**

1. Analysis of oblast data for new payment systems completed.<sup>4</sup> (Mar. 1996)
2. New payment system framework designed for federal Fund implementation. (Apr. 1996)
3. New payment methods implemented and personnel in oblast pilot health facilities and primary care practices trained in its implementation. (Aug. 1996)

**Output 4. Improved quality assurance, financial and clinical information systems designed and tested in pilot facilities with new provider payment methods.**

Introducing new provider payment systems requires creation of an enabling environment for successful implementation. Components of this environment are financial systems, clinical information systems, and quality assurance systems.

A legacy of central planning is that health facility managers have little information on the true costs of producing health services in their facilities. Adapting to the incentives of the new provider payment systems requires the tools of financial systems to improve decision-making capability and efficient allocation of resources.

Health facility autonomy is required to create competitive conditions within the health care sector. Health facilities are tightly controlled financially by the Ministry of Finance (MOF) and organizationally and medically by the Ministry of Health (MOH). Decentralizing control of health care facilities would allow managers the flexibility they need to adapt to a changing environment and allocate resources more efficiently. In addition, improvements in the national budget allocation process for the health sector would also increase facility autonomy.

Quality assurance systems are designed to ensure that quality standards of care are met in the most cost-effective way possible. Under the Soviet system there was no formal system of quality assurance -- quality was assumed and cost-effectiveness was unimportant. As a result, health care services consume a high level of resources with little or no benefits in clinical effectiveness. Hospital stays, for example, can be reduced significantly for some conditions or even eliminated completely if modern drugs and treatment practices were used.

In addition to improving resource utilization, facility-based quality assurance systems will be required to counteract the perverse financial incentives created by the new provider payment systems, i.e. providers taking short-cuts in quality of care to save money. For example, the incentive for length of stay in the hospital would be completely inverted, from keeping patients in the hospital for as long as possible to discharging them as soon as possible. Quality assurance systems will ensure that patients are not discharged prematurely.

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<sup>4</sup> The federal BHI Fund will be responsible for collecting and compiling oblast data for analysis.

Training in cost accounting systems and internal quality assurance has already been provided to BHI Fund, health administration and selected facility personnel in the three oblast pilot areas, South Kazakhstan, Dzhezkasgan and Almaty. Continued assistance will be continue to provided in parallel with the development and implementation of new payment methods at the national and oblast level.

The targets to be used to measure progress in achieving Output 4 are:

- 6. Number of health care facilities in pilot areas with improved quality assurance systems increased from 0 to 20 by 10/96.**
- 7. Number of health care facilities in pilot areas with improved financial and clinical information systems for resource management increased from 0 in 12/94 to 20 by 6/96.**

#### **Specific Activities and Completion Date:**

1. Cost accounting systems, clinical information systems, and financial systems designed and installed in pilot health facilities and key personnel trained. (Sept. 1996)<sup>5</sup>
2. Analysis completed of treatment protocols for majority of hospital admissions and ne new cost-effective protocols tested in pilot facilities (July 1996)<sup>6</sup>
3. Hospital quality assurance systems designed and tested in pilot facilities (Oct. 1996)

#### **IV. MONITORING AND EVALUATION**

The program will measure implementation progress through a monitoring and evaluation database which will track results of all activities as they relate to the four planned Outputs. Data on the program indicators will be periodically collected, i.e. bi-annually, through report and record reviews, surveys, and site visits to document progress.

Routine reporting and monitoring functions will be continue to be carried out using a standardized format, reporting progress against the targets. Reports will be submitted on a weekly basis, with bi-annual summaries generated for the Monitoring and Reporting System.

#### **Specific Activities and Completion Date:**

1. Project reports submitted bi-annually to USAID/CAR. (Feb., Aug., 1996)

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<sup>5</sup> This activity is dependent upon the disposition of the \$80,000 IRM plan for procurement of computers for counterpart facilities, which was submitted in August 1995.

<sup>6</sup> This activity to be carried out in collaboration with AIHA Program.

2. Monitoring and evaluation activities carried out to measure progress in achieving outputs and impact indicators. (Dec. 1996)

#### **IV. GRANT PROGRAM TO SUPPORT NON-GOVERNMENTAL SERVICES AND INNOVATIVE REFORMS IN FINANCE AND SERVICE DELIVERY**

This section outlines the process for awarding grants, the grants are included as specific activities in the health sector financing and health sector efficiency sections.

The absence of alternatives to the government health system limits innovation and restricts competition and consumer choice. The expected result of ZdravReform small grants program is the expansion of health care reform initiatives and increased practical experience and support for reform-minded individuals and institutions. The total amount budgeted for grants is \$170,000. Of this, \$106,000 is earmarked for eight grants already in the award pipeline; the remaining \$64,000 will be used to fund an additional 5-6 grants.

A Grants Program Management Manual describes the procedures that are used to award grants. The following schedule of activities will be carried out:

1. Grant proposals in "pipeline" awarded (Feb. 1996)
2. Assistance to prospective grantees in preparing new grant applications. (Feb. 1996)
4. Grant applications reviewed by Grants Committee. (Mar. 1996)
5. Grants awarded (May 1996).

#### **VI. COORDINATION WITH OTHER HEALTH SECTOR DONORS AND USAID PROJECTS**

The program will collaborate with other donors to increase the impact and synergy of reforms in the health sector. Areas of activity coordination and collaboration are as follows:

##### **Pharmaceutical Sector:**

USAID -- Privatization contractors  
Other Donors -- World Bank

##### **Health Sector Financing and Efficiency:**

USAID -- AIHA Hospital Partnership Project, Centers for Disease Control  
Other Donors -- Know How Fund, World Bank, Overseas Development Administration, Mercy Corps International.

##### **Grants Program:**

USAID -- American Legal Consortium, Counterpart Consortium

**Technical Assistance Requirements for ZdravReform Program**  
**January - December, 1996**

A. Pharmacy Privatization.

Provide continued assistance to national and oblast authorities in preparing for and implementing privatization of wholesale and retail Farmatsiya operations. Provide assistance to Ministry of Health in drafting fair and transparent regulations for licensing of drug distribution, pharmacies, and pharmacists.

Assist in developing and implementing Information/Education campaign to create public awareness of privatization benefits. Develop and implement training and technical assistance program for post-privatization support to health care professionals and pharmacy managers, in collaboration with USAID contractors SOMARC and Carana and Turkish senior consultants.

Estimated LOE<sup>1</sup>: 54 PM Estimated Cost: \$560,000

B. Drug Information Systems/Formularies

Provide continued assistance to health authorities in finalizing national essential drug list. Provide follow-on assistance to Dzhezkasgan Ministry of Health to implement Oblast formulary, and collaborate with local health professionals to finalize hospital and outpatient formularies developed for pilot facilities in Almaty, Shymkent, Dzhezkasgan, and Atyrau. Design a model procurement systems developed for implementation of oblast and facility formulary systems. Design and assist in implementing national and/or oblast monitoring system to track availability and prices of formulary drugs. Finalize development of a drug information system to support the formulary system and develop and conduct educational programs for physicians from pilot oblast and pilot facilities with formularies.

Estimated LOE\*: 27 PM Estimated Cost: \$95,000

C. New Provider Payments

Provide technical assistance to the federal BHI Fund in the design of new payment methods for nationwide implementation, and provide policy guidance on regulations regarding quality assurance, minimum benefit package and information systems, and rationalization policy for oblast implementation. Provide continued assistance to local city and oblast health departments and facility

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<sup>1</sup>\* Includes local and US short-term consultants; all others include estimates for only US short-term consultants, approximately \$25,000 per person month.

personnel in designing and organizing the structure and systems for the following payment method experiments: (1) South Kazakstan to establish a health maintenance organization (HMO) and primary care fundholding in selected family practices, (2) Dzhezkasgan to refine payment methods for hospitals and private practices, and (3) Almaty oblast to implement primary care fundholding systems in two pilot polyclinic facilities.

Estimated LOE: 8 PM Estimated Cost: \$210,000

#### D. Quality of Care

Assistance will be provided to gather data gather and analyze practice protocols for the majority of hospital admissions and most common outpatient conditions. New cost-effective protocols, based on US models, will be developed in conjunction with leading specialists and head physicians in the Ministry of Health. Assistance will be given to test and evaluate outcomes of implementation of the new practice protocols for high volume/high cost services in pilot facilities.

A new quality assurance system will be designed for BHI Fund to monitor new hospital and primary care payment systems. The core of the system will be hospital admission and discharge criteria based on the new practice protocols. In addition, a primary care quality system will be designed based on referral rates and the provision of key primary care services such as immunization. Training will be provided to personnel of the pilot health facilities to implement the new quality assurance systems. (Note: the QA systems will be designed according to the mandate of the federal MHI fund.)

Estimated LOE: 7 PM Estimated Cost: \$175,000

#### E. Infrastructure Development

Follow-on assistance provided in training accounting personnel in federal BHI Fund and oblast pilot areas on cost accounting system. Clinical information system and financial systems designed and installed in pilot health facilities and key personnel trained. The installation and implementation of computer systems in pilot facilities is dependent upon obtaining approval from on the information systems plan, submitted to the IRM in August, 1995. (Note: Regional Office local information system specialists will provide a significant portion of the assistance to counterparts for this activity.)

Estimated LOE: 3.5 PM Estimated Cost: \$85,000

#### F. Information Dissemination

Continued dissemination of information and products resulting from project activities will be carried out at the national and oblast level. Assistance will be provided in the "packaging" and production of information materials and conducting of in-country training workshops and courses for local counterparts. Information dissemination activities will involve all of the project activity areas. A

second regional technical conference will also be held, if funding permits, in which local counterparts will present and share information on their reform activities.

Estimated LOE: 2 PM Estimated Cost: \$44,000

**Total Estimated LOE: 101.5 Estimated Cost: \$1,169,000**

<b>Budget D. FY 1996 &amp; FY 1997 (Oct-Dec)</b>						
<b>Budget Plan Oct. 1, 1995 - Dec. 31, 1996</b>						
<b>Assumption: FY 1996 Obligated Funds = 1,800,000</b>						
<b>Background:</b>	<b>Kazakstan</b>	<b>Kyrgyzstan</b>	<b>Uzbekistan</b>	<b>Turkmenistan</b>	<b>TOTAL</b>	
<b>Obligated</b>	5,868,063	1,620,540	500,000	250,000	8,238,603	
<b>Expended 9/30/95</b>	4,014,716	998,687	88,899	95,887	5,198,189	
<b>Remaining 10/1/95</b>	<b>1,853,347</b>	<b>621,853</b>	<b>411,101</b>	<b>154,113</b>	3,040,414	
<b>Reobligate UZ &amp; TK</b>	<b>100,000</b>	<b>465,214</b>	<i>(Close-out)</i>	<i>(Close-out)</i>	565,214	
<b>1996 FUNDS AVAILABLE</b>	1,953,347	1,087,067			3,040,414	
<b>1996 FY FUNDS OBLIGATED</b>	1,000,000	800,000				
<b>US-Turkey Funds</b>	655,000					
<b>TOTAL</b>	<b>3,608,347</b>	<b>1,887,067</b>			<b>5,495,414</b>	
<b>1996 Budget Breakdown (\$000's)</b>						
	<b>FY 96</b>	<b>FY 97</b>	<b>FY 96</b>	<b>FY 97</b>		
<b>Mgt. Admi. &amp; Operating Costs</b>						
Regional Office*	1050	262.5	545	136.25	1993.75	
Headquarters	275	61	164	26	526	
IDS Office	98	10	115	28.75	251.75	
<b>Sub-total</b>	<b>1423</b>	<b>333.5</b>	<b>824</b>	<b>191</b>	<b>2771.5</b>	
* Includes US advisors and Regional Office local technical consultants						
<b>National Level - Technical Assistance</b>						
Pharmacy Privatization	560	140			700	
Drug Info Sys/Formularies	95	23.75			118.75	
New Provider Payments	50	12.5			62.5	
Quality of Care	50	12.5	103		165.5	
Infrastructure Development	25	6.25			31.25	
Information Dissemination	44	11	36	9	100	
<b>Sub-total</b>	<b>824</b>	<b>206</b>	<b>139</b>	<b>9</b>	<b>1178</b>	
<b>Oblast Level - Technical Assistance, Grants, Commodities</b>						
Health Insurance	5		5			
New Provider Payments	200	75	125	42	442	
Quality of Care	175	25	95	5	300	
Primary Care			150	32	182	
Infrastructure Development	60	15	100	25	200	
Information Dissemination	13	3.25	5		21.25	
Small Grants Program	170		70		240	
Commodities - Computers	80		70		150	
<b>Sub-total</b>	<b>703</b>	<b>118.25</b>	<b>620</b>	<b>104</b>	<b>1545.25</b>	
<b>Grand Total</b>	<b>2950</b>	<b>657.75</b>	<b>1583</b>	<b>304</b>	<b>5494.75</b>	

<b>REGIONAL OFFICE and IDS TEAM RESPONSIBILITIES</b>												
<b>Staff</b>	<b>Area of Responsibility</b>											
	<b>Mgmt.</b>	<b>Admin.</b>	<b>Pharmacy Privatize</b>	<b>Drug Info Formulary</b>	<b>Payment Systems</b>	<b>Quality of Care</b>	<b>Primary Care</b>	<b>Infrastruc Develop.</b>	<b>Grants</b>	<b>Private Practice</b>	<b>Rational-ization</b>	<b>Inform. Dissemin</b>
<b><u>Regional Office</u></b>												
<b><u>US LTA</u></b>												
Borowitz	X		X	X	X	X	X				X	X
Copeland	X	X							X		X	X
O'Dougherty					X		X	X			X	X
Slaski		X							X	X		
Krakoff			X	X						X		X
<b><u>Local Technical Staff</u></b>												
Kayrgeldin		X										
Poltorkina		X			X							X
Danilenko						X						X
Almagambetova				X		X	X					
Karakoulov			X	X								
Kutanov					X			X				
Timoshkin					X			X				
Siderenko					X			X				
Sukurov									X			
Nugumenova				X		X						X
Kelezbek				X								
Nurzhanov				X		X						X
<b><u>Issyk-Kul IDS Office</u></b>												
<b><u>US LTA</u></b>												
Millslagle	X					X	X		X		X	X
<b><u>Local Technical Staff</u></b>												
Mukanova		X					X					X
Ismailova					X	X		X			X	X
Ibragimov							X					X
Abdrakhmanov		X						X	X			
Ahmatov							X					X
<b><u>South Kazakstan Office</u></b>												
<b><u>Local Technical Staff</u></b>												
Miglina	X	X							X			X
Samchenko				X	X	X				X		X